

may request that CMS withhold a part of its monthly per capita payment in a benefit stabilization fund. The fund will be used to prevent excessive fluctuation in the provision of those additional benefits in subsequent contract periods.

(b) *Notification to CMS.* An HMO's or CMP's request to have monies withheld in a benefit stabilization fund must be made when the HMO or CMP notifies CMS under §417.592(d) of its ACR and its ACPRP in preparation for its next contract period.

(c) *Limitations on the amounts withheld—*(1) *Limit per contract period.* Except as provided in paragraph (c)(3) of this section, CMS does not withhold in a benefit stabilization fund more than 15 percent of the difference between an HMO's or CMP's ACR and its ACPRP for a given contract period.

(2) *Cumulative limit.* If CMS has established a benefit stabilization fund for an HMO or CMP, it does not approve a request for withholding made by that HMO or CMP for a subsequent contract period that would cause the total value of the benefit stabilization fund to exceed 25 percent of the difference between the HMO's or CMP's ACR and the average of its per capita rates of payment for that subsequent contract period.

(3) *Exception.* CMS may grant an exception to the limit described in paragraph (c)(1) of this section if an HMO or CMP can demonstrate to CMS's satisfaction that the value of the additional benefits it provides to its Medicare enrollees fluctuates substantially in excess of 15 percent from one contract period to another.

(d) *Financial management of benefit stabilization funds.* (1) The amounts withheld by CMS to establish and maintain a benefit stabilization fund are in the custody of the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(2) The amounts withheld in a benefit stabilization fund are accounted for by CMS in accounts in which interest does not accrue to the HMO or CMP.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended by 56 FR 46571, Sept. 13, 1991; 58 FR 38083, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

§417.597 Withdrawal from a benefit stabilization fund.

(a) *Notification to CMS.* An HMO's or CMP's request to make a withdrawal from its benefit stabilization fund for use during a contract period must be made when the HMO or CMP notifies CMS of its ACR and its ACPRP for that contract period. In making its request, the HMO or CMP must—

(1) Indicate how it intends to use the withdrawn amounts;

(2) Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;

(3) Document the HMO's or CMP's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(4) Document its experience during the contract period previous to the one for which it requests withdrawal to ensure that the HMO or CMP will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(b) *Criteria for CMS approval.* CMS approves a request for a withdrawal from a benefit stabilization fund for use during the next contract period only if—

(1) The HMO's or CMP's average of its per capita rates of payment for the next contract period is less than that of the previous contract period;

(2) The HMO's or CMP's ACR for the next contract period is significantly higher than that of the previous contract period; or

(3) The HMO's or CMP's revenue requirements for the next contract period for providing the additional benefits it provided during the previous contract period is significantly higher than the requirements for that previous period and the ACR for the next contract period results in an additional benefits package that is less in total value than that of the previous contract period.

(c) *Basis for denial.* CMS does not approve a request for a withdrawal from a benefit stabilization fund if the withdrawal would allow the HMO or CMP to—

§ 417.598

(1) Offer without charge the supplemental services it provides to its Medicare enrollees under the provisions of § 417.440 (b)(2) or (b)(3); or

(2) Refinance prior contract period losses or to avoid losses in the upcoming contract period.

(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the HMO or CMP under § 417.584 during the period of the contract.

[58 FR 38075, July 15, 1993, as amended at 60 FR 46233, Sept. 6, 1995]

§ 417.598 Annual enrollment reconciliation.

CMS's payment to an HMO or CMP may be subject to an enrollment reconciliation at least annually. CMS conducts this reconciliation as necessary to ensure that the payments made do not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the HMO or CMP during the contract period. The HMO or CMP must submit any information or reports required by CMS to conduct the reconciliation.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

Subpart Q—Beneficiary Appeals

§ 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a redetermination, reconsideration, hearing, and judicial review for individuals dissatisfied with a determination regarding their Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with CMS to enroll Medicare beneficiaries and furnish Medicare-covered health care services to them.

(3) Section 234 of the MMA requires section 1876 contractors to operate under the same provisions as MA plans where two plans of the same type enter the cost plan contract's service area.

(b) *Applicability.* (1) The rights, procedures, and requirements relating to beneficiary appeals and grievances set

42 CFR Ch. IV (10–1–06 Edition)

forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(2) In applying those provisions, references to section 1852 of the Act must be read as references to section 1876 of the Act, and references to MA organizations as references to HMOs and CMPs.

[60 FR 46233, Sept. 6, 1995, as amended at 62 FR 23374, Apr. 30, 1997; 70 FR 4713, Jan. 28, 2005]

Subpart R—Medicare Contract Appeals

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§ 417.640 Determinations subject to appeal.

This subpart establishes the procedures for making and reviewing the following initial determinations:

(a) A determination that an HMO or CMP is not qualified to enter into a contract with CMS under section 1876 of the Act.

(b) A determination that an HMO or CMP is qualified only for a reasonable cost contract.

(c) A determination to terminate, or to refuse to renew, a contract with an HMO or CMP because—

(1) The HMO or CMP has failed substantially to carry out the terms of the contract;

(2) The HMO or CMP is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of section 1876 of the Act;

(3) The HMO or CMP no longer meets the applicable conditions necessary to qualify as an HMO or CMP under section 1876 of the Act and this subpart; or

(4) The HMO or CMP has failed to comply with the composition of enrollment requirements specified in § 417.413(d).

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46572, Sept. 13, 1991; 58 FR 38080, July 15, 1993]